Health and Community Services Board

Notes of meeting on Monday 12th April 2021 2:30-5:00pm

3rd Floor (Corporate Office), Peter Crill House, St. Helier and via Teams

Board Members Present:	Richard Renouf (Chair)	Minister for Health and Social Services (HSS)	RR
	Trevor Pointon	Assistant Minister for HSS (Chair of the Quality and Risk Assurance Committee)	TP
	Hugh Raymond	Assistant Minister for HSS	HR
	Caroline Landon	Director General HCS	CL
	Patrick Armstrong	Group Medical Director HCS	PA
	Robert Sainsbury	Group Managing Director HCS	RS
	Rose Naylor	Chief Nurse	RN
	Steve Graham	Associate Director of People HCS	SG
	Anuschka Muller	Director of Innovation & Improvement	AM
	Michelle Roach	Head of Finance Business Partnering HCS	MR
	Isabel Watson	Associate Group Managing Director Adult Social Care & Mental Health Service	IW
	Patricia Tumelty	CEO – Mind Jersey	PT
	Judy Foglia	Quality and Governance Lead, Family Nursing and Home Care deputising for Bronwen Whittaker	JF
	Fiona Brennan	CEO Brighter Futures	RB
	Gail Caddell	Acting CEO Jersey Hospice Care	GC
In Attendance:	Danielle Colback	Executive Assistant (taking minutes)	DC
	Beverley Edwards	Head of Informatics HCS	BE
	Martyn White	Head of Communication HCS	MW

Please note: *Minutes have been numbered in accordance with Agenda. Some items have been taken out of order.*

		Action
1.	**Welcome and Apologies** RR welcomed everyone to the HCS Board meeting & introductions made. RR welcomed FB to her first HCS Board meeting, deputising on behalf of RB. Bronwen Whittaker — CEO FNHC — BW Ruth Brunton — CEO Brighter Futures — RB Adrian Noon — Associate Medical Director for Primary, Prevention & Intermediate Care — AN Matthew Doyle — General Practitioner — MD Emma O'Connor — Interim Board Secretary — EOC	
2.	**Declarations of Interest** No declarations of interest	
3.	**Service User Story** RR advised members that this item has been deferred as service users are expressing their wish to deliver this item in person rather than via TEAMS.	
4.	**Professional's Story** GC presented an overview of the plans for a Children's Hospice (slides included).	

	RR thanked GC for the presentation & noted the hard work that has gone into the development of this ambitious plan. In relation to the difference between adult & child palliative care, RR asked if those children on a curative pathway would be receiving medical intervention. GC explained that whilst a child may be on a curative pathway, at those moments when it is hard to predict outcome, it is imperative that an individual receives the care they need. Hospice is not solely concerned with end of life care, it is about living & when individuals are fighting a life-threatening illness, the holistic approach to care during these moments is essential. With adults, palliative care is usually provided within the last 2 years of life: previously last year of life but people are living longer with chronic illness, requiring a broader range of care. There are patients within the in-patient unit at Jersey Hospice who are continuing to receive oncology treatments. CL asked what proportion parent of children / young people prefer to have support provided within the home environment rather than a hospital environment. GC agreed that most parents would prefer home, but they have not previously had this choice. CL asked if there is an intention to provide significant respite care as part of this service, GC anticipates this, but it will require a bespoke specialist team. RN thanked GC for the presentation & highlighted the progress that had been made since initial discussions around palliative care pathways. In response to RNs question about the proposed model, GC confirmed that it is like models seen in similar Island communities. Whilst unable to compare figures (further validation required) GC highlighted that there has been a 50% increase in parents requesting support from the Children's team over the Covid period. RN noted the need for a broader support network for parents, for example, when children were no longer able to attend school, this was very hard for parents to come to terms with as the child was being taken away from an environment were they could play & socialise. RR asked what the transition pathway would be for an adolescent. GC explained that transitionary care could be developed as a seamless process in Jersey. RR thanked GC and asked what the next steps would be. GC explained that there would be engagement with all stakeholders & GC will share the slides with a summary of feedback. The design brief will be shared at the end of quarter 2 2021 & regular updates provided to the Board. In terms of funding, a bid has been made for fiscal stimulus. There will be an income generation strategy which will involve bespoke donors and the public (through charitable fund raising).	
5.	**Minutes of the previous meeting** Pending a change to BW's title, the minutes of the meeting 8th March were agreed. Incorrectly states Governance Lead rather than CEO.	
6.	**Matters Arising and Action Log** Updates provided on action tracker.	
7.	**Chair's Report** RR advised that the Island continues to move through the reconnection road map. Covid activity in Jersey is low but it is very important to remain vigilant &	

	observe all the guidance. RR requested to pay tribute to all those involved in the vaccination programme as it continues to be great success. Covid status certification & how this might be used has been discussed politically in Jersey, as in other jurisdictions. It is likely that it could be used in the future at the borders but the detail of how this will be managed has to be explored. This is also being discussed at Scientific Technical Advisory Cell (STAC). HR advised that he had been approached by one of his parishioners & asked how people are made aware of when their second vaccination is due. RR reassured that everyone is notified as to when there second vaccination will be (rather than have to book this themselves). The Our Hospital project continues to be progressed whilst continuing to seek resolution to the issues of access to the site. A Citizens Jury which is looking at the issue of assisted dying is sitting; presentations have been delivered. RR advised that whilst he does not attend these meeting, feedback suggests that it is a very balanced, thoughtful process. RR advised that himself & Deputy Pointon had taken part in a Youth's States Assembly last week. It was encouraging to see young people engaged in subjects including Mental Health & Covid vaccination passports. RR noted the importance of engaging young people in any further Jersey Care Model workshops, particularly those interested or already undertaking a social care / health related course.	
8.	**Director General's Report** CL advised that Our Hospital work is progressing towards the planning deadline of November 2021.	
9.	**<u>View from the Bridge (Partner Organisations)</u>** <u>Family Nursing and Home Care (FNHC)</u> JF advised there had been a key appointment to the role of CEO in March 2021 with the successful candidate due to start July 2021. There will be a handover period between BW & the incoming CEO anticipated until late Nov / early Dec 2021. Child & Family: Continuing to resume business as usual (BAU) & assessing how to incorporate the new guidance into all services. Except for one post, all efforts to recruit into the Health Visiting (HV) service have been unsuccessful. The HV have presented a new model of working which needs some refinement through workshops & will then be presented to commissioners. The restructuring & remodelling across FNHC aligns to nurse education plans to train on Island. This is an exciting opportunity & training is expected to start in September 2022. In anticipation of this, a decision is awaited from finance & commissioners about two development posts. Looking to recruit two grade 4 staff nurses that will start within the service & commit to the training. District Nursing: This service is running at full capacity.	

Rapid Response: The 24-hour overnight nursing service commenced on 5 April 2021 & to-date is working well. Recruited into one post & advertised in the UK for the remaining WTEs. The night shifts are being covered by existing staff. Following the first week, the feedback has been positive. Working incrementally over the first 3 months to understand how the service will develop in the future.

AM stated it was encouraging to hear the positive feedback in relation to this & asked if there was any data in relation to the service, e.g. number of calls. JF reported that there is limited data at the moment. JF advised that this service has not been widely advertised during this initial phase. The night nursing staff meet with the GPs / JDOC each night to gain an understanding of the service & develop paperwork. JF advised that one of the GPs had noted that the previous weekend had been particularly quiet, but this provided staff with an opportunity to familiarise themselves with the process.

AM agreed that the gradual establishment of the service enabling those involved to gain confidence was the way forward & confirmed this as the reason that there have been no communications about the service.

GC welcomed the establishment of this service. GC asked if JHC were able to refer into this service currently & what the process for this is. JF advised that this was not possible at present as the service was focusing on working with JDOC & taking referrals through JDOC (for the next 3 months).

In relation to the new model of HV, RN asked if the Head of Midwifery & Women & Children's Care Groups (WACS) had been involved both for information & to assess whether there is any impact on service provision (recognising that CYPES are the commissioner not HCS). JF advised that this had been discussed with CYPES, but the model was not ready for wider presentation. However, JF advised that if there is a need to involve any other agencies / healthcare professionals this will be done prior to the launch. In response to RN's question on service impact, JF responded that it would not, this is about ways of working & managing workload rather than service provision.

<u>Jersey Hospice Care (JHC)</u>
GC advised that JHC are also in the process of recruiting to the post of CEO.

GC advised that services have been busy recently with complex presentations in young people requiring acute care. There are patients that are still receiving acute oncology treatment having just received their diagnosis (within the acute inpatient setting). Nursing staff have required support around resilience.

Visiting is starting to resume, particularly the utilisation of outdoor space as the weather improves. Caution is still required as the majority of JHC patients are not vaccinated. This is challenging for relatives as they want to spend as much time as possible with their loved one but JHC must consider the safety of vulnerable patients.

The complimentary therapy post, in conjunction with MacMillan, has been utilised within the inpatient service for both patients and families (whilst not opened the Kings Centre). The feedback has been tremendous.

There is ongoing work to review how all staff can safely return to the workplace.

Discussions have commenced with community physiotherapy to deliver group work within the gym.

The recruitment of a palliative care consultant is underway & this role will be crucial as it is Island wide & fits with the Jersey Care Model (JCM).

GC will be meeting with the Medical Service Care group & commissioners later this week to discuss palliative care provision in the hospital & the implementation & embedding of the Gold Standard Framework (GSF). Also anticipating discussion around the difference between specialist palliative care & general specialist care & what the boundaries of this care are.

In response to RR's question, GC advised that an educational model was introduced over six years ago across every care sector in Jersey around what the last year of life should look like, advance care planning, what communication should be, how to support patients & families with an advanced care plan & how to support people at end of life. This is the GSF & there was a two-year implementation plan. GC explained it is important to ensure that this learning continues to be embedded in practice.

RN suggested it would be helpful to have nursing representation at the meeting discussing end of life of care & will discuss this with the Medical Services Care Group triumvirate.

<u>MIND Jersey</u>
The youthful mind project took part in the States Assembly last week which was well received. Also supporting the Citizens Panel to ensure that their own mental health & wellbeing is supported through this process. The closing date for the mental health inclusion survey has been extended to the end of June 2021 with the aim to have a strategic advisory panel for services for diverse communities.

The response to the pandemic continues. Now seeing the effects of debt, housing, loneliness which not only effect the mental health of individuals but also affect relationships. As part of the recovery plan, investment has been made in peer support across all ages and stages. The co-production of a new commissioning framework presents opportunities to work with colleagues as to how Mind Jersey can help shape the pandemic recovery plan. Looking forward to the publication of the wider piece of Public Health analysis with recommendations that will support further work.

In terms of lobbying, there is a balance between advertising the effects on individual's mental health and not catastrophising and spreading fear among people. Mind Jersey are keen to work with all colleagues delivering mental health services in the development of a more joined up, coherent narrative in terms of the recovery plans & what this will look like (to avoid duplication).

RR thanked PT & advised that there had been a discussion around post pandemic recovery in the Council of Ministers (COM) & the needs around mental health particularly for children & young people.

<u>Brighter Futures</u>
FB advised that the service is continuing to see a lot of financial issues for many families & providing much more support in terms of food vouchers / food parcels & delivery of essential items where parents are unable to leave the home. This position is improving slightly.

	The eleven new groups recently introduced will continue to run through to July 2021 as it has unfolded that there are a number of babies coming through the service that have never seen other babies. This provision will then be reviewed in July 2021. For the last 10 weeks, the service has been operating between 170-175 families / week representing a significant increase for the average of 150 / week. If this increases further to 180 families / week, might have to consider starting a waiting list which is something that Brighter Futures has never needed before. FB will continue to up-date the Board on this position. RR asked in the cases where families are requiring food vouchers / parcels, will this start to resolve as more people are able to return to work or is this more permanent. FB stated this was multifactorial & even where people can return to work, there may be long term debts that families must manage. From a Mental health perspective, some parents that could return to work do not feel ready or able to. A service is being introduced for children in schools which has been gratefully received by the schools, children & parents. FB suggested that the full impact upon the mental health of families is not yet realised. <u>Jersey Alzheimer's Association</u> Apologies sent. <u>General Practice</u> Apologies sent.	
10.	**HCS Board Terms of Reference** RR advised that initially this item is to discuss the frequency of the Board which is presently every 4-5 weeks, aligned with the HCS committee structure. RR acknowledges that this represents a considerable time commitment from members & asked members whether there would be more value from less frequent meetings (in terms of content & strategic oversight). RR invited members for their views on reducing the frequency to quarterly. CL suggested that a move to quarterly would be a good way forward & make the board more meaningful, facilitating sharing of information from a wider variety of sources, particularly as the JCM is progressed. HR stated it would be useful to plan the Board to align with the financial meetings & suggested that if there were any urgent financial meetings, an extraordinary meeting could be convened. MR echoed this comment advising it is important that the Board receives the most up-to-date information. GC & PT feel that quarterly meetings would facilitate the Board to become more strategic, reporting key themes with action plans that link to the overall strategic objectives. Those stakeholders with a commissioning / partnership agreement would be able to report back to the Board rather than the view from the bridge item. There would be more robust data available to support this. AM reassured the Board that financial report is received at the Operation, Performance & Finance (OPF) Committee monthly which provides in-depth assurance around the finances. It was agreed by the Board that the meetings would become quarterly.	

	RR added that when discussing the HCS assurance committee reports, involvement & challenge is invited: holding each other to account for the delivery of healthcare in Jersey is the function of the Board.	
11.	**Quality and Performance Report February 2021** RR welcomed BE to the meeting. This report provides assurance & evidence to the OPF committee before presentation to the Board. The report has evolved over the last couple of months to align with HCS governance. The Care Group Performance Reviews are provided with the draft report for consideration. At each meeting, the intention is to look either at performance highlights or in-depth reviews. To-date an in-depth review for Mental Health & Emergency Department (ED) has been presented. The intention is to bring the highlights to the Board. Main points: • The number of ED attendances over the last few months has reduced this year when compared to the same time last year. This is thought to be due to the covid restrictions in place & will be monitored as the restrictions are reduced. • The number of people on the inpatient elective waiting list has changed very little in the last 12 months. • The number of people on the outpatient elective waiting list has increased to 53% (waiting over 90 days). This will cause a consequential short term rise in the in-patient list. • Inpatient elective activity has increased by 8% year to-date than this time last year: day case is 21% lower than this point last year. Overall activity is 15% lower than the first two months of last year. More exploration is required as to the type of activity as this is just a count of people being seen. • The overall outpatient waiting list has reduced compared to last month, although 2% higher than this time last year. • Two specialities which have seen significant & sustained decline in waiting list are Urology, from 297 at end Jan 2021 to 180 end Feb 2021 & Dermatology, from 602 to 462. The weekly challenge meetings have been noted to be a major contributor to the overall reduction. • Referrals to adult mental health outpatients have reduced by 31% year to date compared to the same time last year. • The service redesign implemented during 2020 has resulted in a 4% lower caseload in community mental health team compared to the same time last year. • General improvement in the performance indicators for the Women, Children & Family Care Group: c-section rate is the lowest it has been for the last 13 months at 29%. The unscheduled c-section rate is the 2nd lowest in the last year at 10%. • There has been a reduction in the percentage of women who had an induced labour & a reduction in the average length of stay on the maternity ward. This is in the context of 25% more deliveries than in the same month last year. RS added, • Length of stay (LOS) over 7 days as a year on year comparison is encouraging: 120 in Feb 2021 compared to 152 in Feb 2020. • In relation to Mental Health, the service redesign is having a positive impact. This is an earlier adopter of the JCM in terms of care outside hospital.	

	• Continuing pressure noted in the CAMHS service with a 3% month on month growth in caseload. • Whilst there is an increase in ED attendance month on month, it is still significantly lower than previously. There was a reduction in 2020 & further reduction 2021. In response to RR's questions about the monthly challenges meetings, RS explained that this is led by M. West (Associate Managing Director) & is a challenge meeting with the Care Groups to go through the Patient Tracking List (PTL) to ensure that patients are progressed according to priority & scheduling is correct & maximising capacity. Whilst early days, this is making a positive difference. The challenge meetings are trying to address the inpatient & outpatient waiting lists. RR thanked BE / RS & invited questions. GC asked BE how the reduction in MH referrals could be reconciled with the community impact of covid. RS responded that growth is noted in the services that are directly accessible such as listening lounge with individuals presenting with anxiety / unemployment & general MH worries. In terms of the statutory services provided by HCS, starting to see some benefits from the investment including the home treatment team & streamed triage with SOJ Police. IW added that the integration of MHS & Adult Social Care (ASC) has absorbed some of this as the 6-month integration is already seeing improvements. Within safeguarding, there has been an increase in referrals related to MH & ASC is providing the support. GC reflected that this demonstrated collaborative partnerships working to deliver a more holistic MH service. IW stated that multiagency working is key with the help of private providers. PT advised that Mind Jersey is working with community MH teams to manage caseload.	
12.	**Finance report** The paper was taken a read. Main points, • Financial position as at end Feb 2021: £25,000 overspend which is 0.6% year to date budget, providing an indication of a good position although there will be fluctuations. Covid expenditure is excluded which is currently under review with business cases being put forward to offset these costs as they are recurring. RR invited questions. HR asked for clarity which schemes were put on hold during 2020 & impact of covid. MR responded that during 2020, 9 million of efficiencies were applied across HCS & savings had to be made. With Covid, a number of these schemes had to be paused. The efficiencies were not fully realised last year but working to take these forward with the 2021 efficiencies having just been applied. MR confident that with the work being undertaken, these savings will be achieved this year.	
13.	**Committee Report – Quality and Risk Assurance Committee** RR invited TP to comment. TP advised that the last two assurance committee meetings have clashed with prior commitments so unable to Chair to-date. RN advised that the paper covers the key items that were discussed at the last committee meeting. • This committee is now Quality & Risk, as performance has moved to another assurance committee. This allows more time to focus on risk & the risk register discussions. Now starting to see positive work from	

	the Care Groups in relation to their governance arrangements, the management of risk registers & the work done through the CGPR. During the risk register item, all the changes were reductions in risks due to mitigation & actions that had been put in place. There are no risks to escalate to the Board. • Improvement in performance in the management of complaints has been noted. This has been a challenge for a period & has been previously discussed at Board. There are regular meetings with the complaint leads & care groups with significant improvement particularly in Mental Health & Surgical Services. Work continues to progress in the other care groups. Will continue to monitor this monthly through the committee. • Women, Children & Family Care (WACS) have been running a task & finish since Sept 2020 & provide a very detailed reports for assurance to the committee monthly. Maternity services are also going through scrutiny with a final meeting being held tomorrow. The care group have undertaken a considerable amount of work & the care group performance review report encompasses the task & finish actions which are nearly complete. • A very detailed paper was provided by Prevention, Primary & Intermediate Care Group in relation to the retinal screening programme; work undertaken & provided good assurance on progress and pace, particularly in relation to a month on month of increase in patients attending for screening with a further projected demand for services. This report will be provided to the committee on a quarterly basis. CL asked for further information in future reports, • The numbers for the retinal screening programme could be included as it is a significant risk for HCS. • The number of red actions from WACS task & finish. • The number of complaints. RR commented that it would be useful to understand the timeline for the retinal screening programme. RN responded that a more detailed report will be provided in future. RR thanked RN / TP & stated it was encouraging to understand how risk was being managed through the care groups.	
14.	**Committee Report – Operation, Performance and Finance** RR advised that HR will be taking the role of Chair for this committee next month & thanked HR. RR invited AM to highlight any key points from the meeting. • This was the second meeting of the committee where the updated terms of reference were agreed. The meeting also included a patient story at the beginning which members found useful. • An in-depth presentation of ED activity resulted in good committee discussion. • The monthly PTL report was presented by M. West & included further updates on the weekly challenge meetings & detail provided for each of the specialities. The committee did challenge some areas including the trajectory & those longer waiting patients: this will be reported back in May 2021. • The financial report was presented by M. Roach. Financial challenges were picked up in both this report & prior to this through the CGPR.	

	• An in-depth estates & backlog maintenance report was provided. • The portfolio of change report was presented to this committee for the first time with a holistic view of all change across HCS which provides the baseline for the JCM & also overall to manage improvement across HCS. In relation to the PTL, CL asked if this was being discussed at Quality & Risk Committee. RN confirmed not as the report was transferred to OPF. CL suggested this may be an area that crossed committees. RS advised that the General Managers have had early engagement with the Deputy Medical Director and planning on undertaking a potential harm review on all those individuals who have been waiting a long time. The output from this will feed into the CGPR, the quality element will feed into the Quality & Risk Committee rather than OPF Committee. HR asked if the OPF committee would receive assurance in relation to the movement of services from Overdale. AM advised that there have been discussions as to how maintain oversight of Our Hospital work in general, but this has not yet been determined. AM clarified that all existing services are monitored. CL confirmed that the Our Hospital governance had oversight of this & to reinforce HR's comment, need to ensure that there is no reduction in quality of service as the services move.	
15.	**Committee Report – People and Organisational Development** SG advised that the most recent committee had been postponed & would be taking place in two weeks to realign with the revised reporting cycle. RR invited SG to discuss any key workforce issues. • SG advised that workforce planning is starting. • The response to BeHeard survey is being developed. These are two large pieces of work which will be reported at Board.	
16.	**Any Other Business** HR requested to make all aware of the work going on in relation to the communication & engagement around the building of the new hospital. HR advised that there is an opportunity to use Fort Regent due to the numbers of people accessing the building (for vaccinations). There are display board & planning video screens to show people exactly what is going to happen & how the hospital at Overdale will be rebuilt. Also looking to use sponsored social media post, online public exhibitions, digital advertising within bus station & onboard buses, large screen at Charing Cross & posters in key government buildings across the Island. Senator Farnham & Dr A. Handa will be discussing this later this week. HR keen to emphasise that both the public & HCS workforce need to be engaged & requested that this messaging is disseminated within areas of responsibility. TP asked what the budget is for the PR exercise. HR responded that this is a valid point for all Islanders & the information should be available soon. RR advised that an allocation for the communication aspects had always been included in the budget. For assurance, CL advised that 45k has been spent on communication, the rest absorbed in the budget. There is a business case coming forward for additional money for communication. However, making every effort to use the resource currently allocated within Government of Jersey (GOJ).	

	RR thanked all members for their contribution to this meeting & closed.	
17.	**Date of Next Meeting** The date of the next meeting to be confirmed following this afternoons decision to reduce frequency.	